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|--|--|-------------|--|--|--|--|--|
| | | FOR OHF USE | | | | | |
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LL I

**2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

| | |
|--|--|
| I. IDPH Facility ID Number: <u>0022897</u> Facility Name: <u>KANKAKEE TERRACE</u> Address: <u>100 BELLAIRE</u> <u>BOURBANNAIS</u> <u>60491</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>KANKAKEE</u> Telephone Number: <u>(847) 674 - 5795</u> Fax # <u>(847) 674 - 5794</u> IDPA ID Number: <u>36-2883311</u> Date of Initial License for Current Owners: <u>10/01/76</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code _____ </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input checked="" type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other _____ </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other _____ </div> </div> | |
|--|--|

In the event there are further questions about this report, please contact:
Name BOB KAGDA **Telephone Number:** (847) 675-3585

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number KANKAKEE TERRACE# 0022897 Report Period Beginning: 01/01/2000 Ending: 12/31/2000**III. STATISTICAL DATA**A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

| | 1 | 2 | 3 | 4 | |
|---|--|-----------------------------|---------------------------------|--|---|
| | Beds at Beginning of Report Period | Licensure Level of Care | Beds at End of Report Period | Licensed Bed Days During Report Period | |
| 1 | | Skilled (SNF) | | | 1 |
| 2 | | Skilled Pediatric (SNF/PED) | | | 2 |
| 3 | <u>136</u> | Intermediate (ICF) | <u>146</u> | <u>51,776</u> | 3 |
| 4 | | Intermediate/DD | | | 4 |
| 5 | | Sheltered Care (SC) | | | 5 |
| 6 | | ICF/DD 16 or Less | | | 6 |
| 7 | <u>136</u> | TOTALS | <u>146</u> | <u>51,776</u> | 7 |

B. Census-For the entire report period.

| | 1 | 2 | 3 | 4 | 5 | |
|----|---------------|---|--------------|------------|---------------|----|
| | Level of Care | Patient Days by Level of Care and Primary Source of Payment | | | | |
| | | Public Aid Recipient | Private Pay | Other | Total | |
| 8 | SNF | | | | | 8 |
| 9 | SNF/PED | | | | | 9 |
| 10 | ICF | <u>45,639</u> | <u>1,248</u> | <u>757</u> | <u>47,644</u> | 10 |
| 11 | ICF/DD | | | | | 11 |
| 12 | SC | | | | | 12 |
| 13 | DD 16 OR LESS | | | | | 13 |
| 14 | TOTALS | <u>45,639</u> | <u>1,248</u> | <u>757</u> | <u>47,644</u> | 14 |

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 92.02%)D. How many bed-hold days during this year were paid by Public Aid?
2,262 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONEF. Does the facility maintain a daily midnight census? YESG. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 10/01/76J. Was the facility purchased or leased after January 1, 1978?
YES ☐ Date _____ NO ☒K. Was the facility certified for Medicare during the reporting year?
YES ☐ NO ☒ If YES, enter number
of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASISMODIFIED
ACCRUAL ☒ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Print Preview

IF AN ERROR OCCURS IN LINE 8, 16 OR 28, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **KANKAKEE TERRACE** # **0022897** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**
V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

| | Operating Expenses | Costs Per General Ledger | | | | Reclass-ification 5 | Reclassified Total 6 | Adjust-ments 7 | Adjusted Total 8 | FOR OHF USE ONLY | |
|-----|---|--------------------------|---------------|------------|------------|------------------------|----------------------------|-------------------|------------------------|------------------|-----|
| | | Salary/Wage 1 | Supplies 2 | Other 3 | Total 4 | | | | | 9 | 10 |
| | A. General Services | | | | | | | | | | |
| 1 | Dietary | 169,032 | 13,387 | 6,415 | 188,834 | | 188,834 | 0 | 188,834 | | 1 |
| 2 | Food Purchase | | 169,975 | | 169,975 | | 169,975 | 0 | 169,975 | | 2 |
| 3 | Housekeeping | 155,318 | 15,609 | 0 | 170,927 | | 170,927 | 0 | 170,927 | | 3 |
| 4 | Laundry | 67,543 | 13,177 | 1,918 | 82,638 | | 82,638 | 0 | 82,638 | | 4 |
| 5 | Heat and Other Utilities | | | 103,976 | 103,976 | | 103,976 | 79 | 104,055 | | 5 |
| 6 | Maintenance | 27,030 | 18,249 | 21,545 | 66,824 | | 66,824 | 2,761 | 69,585 | | 6 |
| 7 | Other (specify):* | | | 5,101 | 5,101 | | 5,101 | 0 | 5,101 | | 7 |
| 8 | TOTAL General Services | 418,923 | 230,397 | 138,955 | 788,275 | | 788,275 | 2,840 | 791,115 | | 8 |
| | B. Health Care and Programs | | | | | | | | | | |
| 9 | Medical Director | | | 2,492 | 2,492 | | 2,492 | 0 | 2,492 | | 9 |
| 10 | Nursing and Medical Records | 907,390 | 32,221 | 4,915 | 944,526 | | 944,526 | 1,070 | 945,596 | | 10 |
| 10a | Therapy | 57,634 | | 5,538 | 63,172 | | 63,172 | 0 | 63,172 | | 10a |
| 11 | Activities | 56,835 | 2,605 | 4,225 | 63,665 | | 63,665 | 0 | 63,665 | | 11 |
| 12 | Social Services | 119,631 | | 1,950 | 121,581 | | 121,581 | 0 | 121,581 | | 12 |
| 13 | Nurse Aide Training | | | 0 | | | | 0 | | | 13 |
| 14 | Program Transportation | | | 0 | | | | 0 | | | 14 |
| 15 | Other (specify):* | | | | | | | 0 | | | 15 |
| 16 | TOTAL Health Care and Progra | 1,141,490 | 34,826 | 19,120 | 1,195,436 | | 1,195,436 | 1,070 | 1,196,506 | | 16 |
| | C. General Administration | | | | | | | | | | |
| 17 | Administrative | 61,141 | | 359,161 | 420,302 | | 420,302 | (323,877) | 96,425 | | 17 |
| 18 | Directors Fees | | | 0 | | | | 0 | | | 18 |
| 19 | Professional Services | | | 57,642 | 57,642 | | 57,642 | 13,744 | 71,386 | | 19 |
| 20 | Dues, Fees, Subscriptions & Promotions | | | 7,504 | 7,504 | | 7,504 | (843) | 6,661 | | 20 |
| 21 | Clerical & General Office Expense | 56,507 | 12,883 | 102,924 | 172,314 | | 172,314 | (60,578) | 111,736 | | 21 |
| 22 | Employee Benefits & Payroll Taxes | | | 265,065 | 265,065 | | 265,065 | 0 | 265,065 | | 22 |
| 23 | Inservice Training & Education | | | 1,063 | 1,063 | | 1,063 | 70 | 1,133 | | 23 |
| 24 | Travel and Seminar | | | 1,501 | 1,501 | | 1,501 | 0 | 1,501 | | 24 |
| 25 | Other Admin. Staff Transportation | | | 29,627 | 29,627 | | 29,627 | 549 | 30,176 | | 25 |
| 26 | Insurance-Prop.Liab.Malpractice | | | 52,672 | 52,672 | | 52,672 | 1,302 | 53,974 | | 26 |
| 27 | Other (specify):* | | | 0 | | | | 8,083 | 8,083 | | 27 |
| 28 | TOTAL General Administration | 117,648 | 12,883 | 877,159 | 1,007,690 | | 1,007,690 | (361,550) | 646,140 | | 28 |
| 29 | TOTAL Operating Expense (sum of lines 8, 16 & 28) | 1,678,061 | 278,106 | 1,035,234 | 2,991,401 | | 2,991,401 | (357,640) | 2,633,761 | | 29 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

IF AN ERROR OCCURS IN LINE 37 OR 44, PLEASE ROUND ALL CELLS IN THE APPLICABLE SECTION TO ZERO DECIMAL PLACES.

STATE OF ILLINOIS

Page 4

Facility Name & ID Number **KANKAKEE TERRACE** # **0022897** Report Period Beginning: **01/01/2000** Ending: **12/31/2000**

V. COST CENTER EXPENSES (continued)

| | Capital Expense | Cost Per General Ledger | | | | Reclass- ification | Reclassified Total | Adjust- ments | Adjusted Total | FOR OHF USE ONLY | |
|----|---|-------------------------|----------|-----------|-----------|-----------------------|-----------------------|------------------|-------------------|------------------|----|
| | | Salary/Wage | Supplies | Other | Total | | | | | 9 | 10 |
| | D. Ownership | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | | |
| 30 | Depreciation | | | 114,424 | 114,424 | | 114,424 | 4,986 | 119,410 | | 30 |
| 31 | Amortization of Pre-Op. & Org. | | | 2,112 | 2,112 | | 2,112 | 0 | 2,112 | | 31 |
| 32 | Interest | | | 255,077 | 255,077 | | 255,077 | (105,071) | 150,006 | | 32 |
| 33 | Real Estate Taxes | | | 45,714 | 45,714 | | 45,714 | 1,502 | 47,216 | | 33 |
| 34 | Rent-Facility & Grounds | | | | | | | 0 | | | 34 |
| 35 | Rent-Equipment & Vehicles | | | 21,396 | 21,396 | | 21,396 | 4,530 | 25,926 | | 35 |
| 36 | Other (specify):* IME | | | 9,450 | 9,450 | | 9,450 | (9,450) | | | 36 |
| 37 | TOTAL Ownership | | | 448,173 | 448,173 | | 448,173 | (103,503) | 344,670 | | 37 |
| | Ancillary Expense | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | |
| 38 | Medically Necessary Transportation | | | | | | | 0 | | | 38 |
| 39 | Ancillary Service Centers | | | | | | | 0 | | | 39 |
| 40 | Barber and Beauty Shops | | | | | | | 0 | | | 40 |
| 41 | Coffee and Gift Shops | | | | | | | 0 | | | 41 |
| 42 | Provider Participation Fee | | | 77,664 | 77,664 | | 77,664 | 0 | 77,664 | | 42 |
| 43 | Other (specify):* | | | | | | | 0 | | | 43 |
| 44 | TOTAL Special Cost Centers | | | 77,664 | 77,664 | | 77,664 | | 77,664 | | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | 1,678,061 | 278,106 | 1,561,071 | 3,517,238 | 0 | 3,517,238 | (461,143) | 3,056,095 | | 45 |

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **KANKAKEE TERRACE**

0022897

Report Period Beginning: **01/01/2000**

Ending: **2/31/2000**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

| | | 1 Amount | 2 Refer- ence | 3 OHF USE ONLY | |
|----|---|--------------|---------------------|----------------------|----|
| | NON-ALLOWABLE EXPENSES | | | | |
| 1 | Day Care | \$ | | \$ | 1 |
| 2 | Other Care for Outpatients | | | | 2 |
| 3 | Governmental Sponsored Special Program: | | | | 3 |
| 4 | Non-Patient Meals | | 2 | | 4 |
| 5 | Telephone, TV & Radio in Resident Rooms | | | | 5 |
| 6 | Rented Facility Space | | 34 | | 6 |
| 7 | Sale of Supplies to Non-Patients | | 10 | | 7 |
| 8 | Laundry for Non-Patients | | 4 | | 8 |
| 9 | Non-Straightline Depreciation | 3,452 | 30 | | 9 |
| 10 | Interest and Other Investment Income | (106,552) | 32 | | 10 |
| 11 | Discounts, Allowances, Rebates & Refunds | | 2 | | 11 |
| 12 | Non-Working Officer's or Owner's Salary | | | | 12 |
| 13 | Sales Tax | | 2 | | 13 |
| 14 | Non-Care Related Interest | 0 | 32 | | 14 |
| 15 | Non-Care Related Owner's Transactions | | | | 15 |
| 16 | Personal Expenses (Including Transportation) | | 25 | | 16 |
| 17 | Non-Care Related Fees | 0 | 20 | | 17 |
| 18 | Fines and Penalties | | 21 | | 18 |
| 19 | Entertainment | 0 | 20 | | 19 |
| 20 | Contributions | (149) | 20 | | 20 |
| 21 | Owner or Key-Man Insurance | 0 | 22 | | 21 |
| 22 | Special Legal Fees & Legal Retainers | | 19 | | 22 |
| 23 | Malpractice Insurance for Individuals | | 26 | | 23 |
| 24 | Bad Debt | 0 | 27 | | 24 |
| 25 | Fund Raising, Advertising and Promotional | (116) | 20 | | 25 |
| | Income Taxes and Illinois Personal | | | | |
| 26 | Property Replacement Tax | | | | 26 |
| 27 | Nurse Aide Training for Non-Employees | | 13 | | 27 |
| 28 | Yellow Page Advertising | (832) | 20 | | 28 |
| 29 | Other-Attach Schedule DEFERRED MAINT XIX-H | 221 | 6 | | 29 |
| 30 | SUBTOTAL (A): (Sum of lines 1-29) | \$ (103,976) | | \$ | 30 |

OHF USE ONLY

| | | | | | | | | | |
|----|--|----|--|----|--|----|--|----|--|
| 48 | | 49 | | 50 | | 51 | | 52 | |
|----|--|----|--|----|--|----|--|----|--|

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

| | | 1 Amount | 2 Reference | |
|----|---|--------------|----------------|----|
| 31 | Non-Paid Workers-Attach Schedule* | \$ | | 31 |
| 32 | Donated Goods-Attach Schedule* | | | 32 |
| 33 | Amortization of Organization & Pre-Operating Expense | | | 33 |
| 34 | Adjustments for Related Organization Costs (Schedule VII) | (357,167) | SCHED | 34 |
| 35 | Other- Attach Schedule | 0 | ATTACHED | 35 |
| 36 | SUBTOTAL (B): (sum of lines 31-35) | \$ (357,167) | | 36 |
| | (sum of SUBTOTALS | | | |
| 37 | TOTAL ADJUSTMENTS (A) and (B) | \$ (461,143) | | 37 |

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

| | | 1 Yes | 2 No | 3 Amount | 4 Reference |
|----|--|----------|---------|-------------|----------------|
| 38 | Medically Necessary Transport | | X | \$ | 38 |
| 39 | | | | | 39 |
| 40 | Gift and Coffee Shops | | X | | 40 |
| 41 | Barber and Beauty Shops | | X | | 41 |
| 42 | Laboratory and Radiology | | X | | 42 |
| 43 | Prescription Drugs | | X | | 43 |
| 44 | Exceptional Care Program | | X | | 44 |
| 45 | Other-Attach Schedule | | | | 45 |
| 46 | Other-Attach Schedule | | | | 46 |
| 47 | TOTAL (C): (sum of lines 38-46) | | | \$ | 47 |

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb KANKAKEE TERRACE

0022897 Report Period Beginning:

01/01/2000

Ending: 12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

| Operating Expenses | PAGES 5 & 5A | PAGE 6 | PAGE 6A | PAGE 6B | PAGE 6C | PAGE 6D | PAGE 6E | PAGE 6F | PAGE 6G | PAGE 6H | PAGE 6I | SUMMARY TOTALS (to Sch V, col.7) | |
|---|-----------------|-----------|------------|------------|------------|------------|------------|------------|------------|------------|------------|--|-----|
| A. General Services | | | | | | | | | | | | | |
| 1 Dietary | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1 |
| 2 Food Purchase | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 |
| 3 Housekeeping | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3 |
| 4 Laundry | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4 |
| 5 Heat and Other Utilities | 0 | 0 | 0 | 79 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 79 | 5 |
| 6 Maintenance | 221 | 0 | 1,794 | 746 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,761 | 6 |
| 7 Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 7 |
| 8 TOTAL General Services | 221 | 0 | 1,794 | 825 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2,840 | 8 |
| B. Health Care and Programs | | | | | | | | | | | | | |
| 9 Medical Director | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 9 |
| 10 Nursing and Medical Records | 0 | 0 | 1,070 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,070 | 10 |
| 10a Therapy | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 10a |
| 11 Activities | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 11 |
| 12 Social Services | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 12 |
| 13 Nurse Aide Training | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13 |
| 14 Program Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14 |
| 15 Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 15 |
| 16 TOTAL Health Care and Program | 0 | 0 | 1,070 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,070 | 16 |
| C. General Administration | | | | | | | | | | | | | |
| 17 Administrative | 0 | (323,877) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (323,877) | 17 |
| 18 Directors Fees | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 18 |
| 19 Professional Services | 0 | 467 | 13,203 | 74 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 13,744 | 19 |
| 20 Fees, Subscriptions & Promotions | (1,097) | 0 | 254 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (843) | 20 |
| 21 Clerical & General Office Expenses | 0 | 6,557 | (67,184) | 49 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (60,578) | 21 |
| 22 Employee Benefits & Payroll Taxes | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 22 |
| 23 Inservice Training & Education | 0 | 0 | 70 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 70 | 23 |
| 24 Travel and Seminar | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 24 |
| 25 Other Admin. Staff Transportation | 0 | 371 | 178 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 549 | 25 |
| 26 Insurance-Prop.Liab.Malpractice | 0 | 345 | 886 | 71 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,302 | 26 |
| 27 Other (specify):* | 0 | 2,633 | 5,450 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 8,083 | 27 |
| 28 TOTAL General Administration | (1,097) | (313,504) | (47,143) | 194 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (361,550) | 28 |
| TOTAL Operating Expense | | | | | | | | | | | | | |
| 29 (sum of lines 8,16 & 28) | (876) | (313,504) | (44,279) | 1,019 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (357,640) | 29 |

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Summary B

Facility Name & ID Number **KANKAKEE TERRACE**

0022897

Report Period Beginning:

01/01/2000 Ending:

12/31/2000

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary

| | Capital Expense | PAGES 5 & 5A | PAGE 6 | PAGE 6A | PAGE 6B | PAGE 6C | PAGE 6D | PAGE 6E | PAGE 6F | PAGE 6G | PAGE 6H | PAGE 6I | SUMMARY TOTALS (to Sch V, col.7) | |
|----|--|------------------|------------------|-----------------|----------------|------------|------------|------------|------------|------------|------------|------------|--|-----------|
| | D. Ownership | | | | | | | | | | | | | |
| 30 | Depreciation | 3,452 | 229 | 524 | 781 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,986 | 30 |
| 31 | Amortization of Pre-Op. & Org. | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 31 |
| 32 | Interest | (106,552) | 0 | 0 | 1,481 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (105,071) | 32 |
| 33 | Real Estate Taxes | 0 | 0 | 0 | 1,502 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 1,502 | 33 |
| 34 | Rent-Facility & Grounds | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 34 |
| 35 | Rent-Equipment & Vehicles | 0 | 1,674 | 2,856 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 4,530 | 35 |
| 36 | Other (specify):* | 0 | 0 | 0 | (9,450) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (9,450) | 36 |
| 37 | TOTAL Ownership | (103,100) | 1,903 | 3,380 | (5,686) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (103,503) | 37 |
| | Ancillary Expense | | | | | | | | | | | | | |
| | E. Special Cost Centers | | | | | | | | | | | | | |
| 38 | Medically Necessary Transportation | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 38 |
| 39 | Ancillary Service Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 39 |
| 40 | Barber and Beauty Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40 |
| 41 | Coffee and Gift Shops | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 41 |
| 42 | Provider Participation Fee | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 42 |
| 43 | Other (specify):* | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 43 |
| 44 | TOTAL Special Cost Centers | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 44 |
| 45 | GRAND TOTAL COST (sum of lines 29, 37 & 44) | (103,976) | (311,601) | (40,899) | (4,667) | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (461,143) | 45 |

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

Entity Name & ID Number: KANSASKEY TERRACE LLC 4822997

STATE OF ILLINOIS

Report Period Beginning: 01/01/2009

Ending: 12/31/2009

Page: 6

Show Pgs 6A thru 6

Show Pgs 6B thru 6

Hide Pgs 6A thru 6

VI. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

| OWNERS | | RELATED NURSING HOMES | | OTHER RELATED BUSINESS ENTITIES | |
|---------------------|-------------|-----------------------|------|---------------------------------|------|
| Name | Ownership % | Name | City | Name | City |
| SHIRLEY A. STANBRED | | SHIRLEY A. STANBRED | | SHIRLEY A. STANBRED | |
| | | | | SHIRLEY A. STANBRED | |
| | | | | SHIRLEY A. STANBRED | |
| | | | | SHIRLEY A. STANBRED | |
| | | | | SHIRLEY A. STANBRED | |
| | | | | SHIRLEY A. STANBRED | |
| | | | | SHIRLEY A. STANBRED | |

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.
☒ Yes ☐ No

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| Schedule | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Costs of Related Organization | Adjustments for Related Organization Costs (Form 6) |
|----------|------|-----------------|---------|------------------------------|----------------------|---|---|
| V | 17 | MANAGEMENT FEES | 238,363 | EMI ENTERPRISES | | | 238,363 |
| V | 18 | | | | | | |
| V | 19 | OFFICE SUPPLIES | | | | 15,387 | 15,387 |
| V | 20 | OFFICE EXPENSE | | | | 407 | 407 |
| V | 21 | OFFICE EXPENSE | | | | 6,557 | 6,557 |
| V | 22 | OFFICE EXPENSE | | | | 571 | 571 |
| V | 23 | OFFICE EXPENSE | | | | 345 | 345 |
| V | 24 | OFFICE EXPENSE | | | | 263 | 263 |
| V | 25 | OFFICE EXPENSE | | | | 229 | 229 |
| V | 26 | OFFICE EXPENSE | | | | 1674 | 1674 |
| V | 27 | OFFICE EXPENSE | | | | | |
| V | 28 | OFFICE EXPENSE | | | | | |
| V | 29 | OFFICE EXPENSE | | | | | |
| V | 30 | OFFICE EXPENSE | | | | | |
| V | 31 | OFFICE EXPENSE | | | | | |
| V | 32 | OFFICE EXPENSE | | | | | |
| V | 33 | OFFICE EXPENSE | | | | | |
| V | 34 | OFFICE EXPENSE | | | | | |
| V | 35 | OFFICE EXPENSE | | | | | |
| V | 36 | OFFICE EXPENSE | | | | | |
| V | 37 | OFFICE EXPENSE | | | | | |
| V | 38 | OFFICE EXPENSE | | | | | |
| V | 39 | OFFICE EXPENSE | | | | | |
| V | 40 | OFFICE EXPENSE | | | | | |
| V | 41 | OFFICE EXPENSE | | | | | |
| V | 42 | OFFICE EXPENSE | | | | | |
| V | 43 | OFFICE EXPENSE | | | | | |
| V | 44 | OFFICE EXPENSE | | | | | |
| V | 45 | OFFICE EXPENSE | | | | | |
| V | 46 | OFFICE EXPENSE | | | | | |
| V | 47 | OFFICE EXPENSE | | | | | |
| V | 48 | OFFICE EXPENSE | | | | | |
| V | 49 | OFFICE EXPENSE | | | | | |
| V | 50 | OFFICE EXPENSE | | | | | |
| V | 51 | OFFICE EXPENSE | | | | | |
| V | 52 | OFFICE EXPENSE | | | | | |
| V | 53 | OFFICE EXPENSE | | | | | |
| V | 54 | OFFICE EXPENSE | | | | | |
| V | 55 | OFFICE EXPENSE | | | | | |
| V | 56 | OFFICE EXPENSE | | | | | |
| V | 57 | OFFICE EXPENSE | | | | | |
| V | 58 | OFFICE EXPENSE | | | | | |
| V | 59 | OFFICE EXPENSE | | | | | |
| V | 60 | OFFICE EXPENSE | | | | | |
| V | 61 | OFFICE EXPENSE | | | | | |
| V | 62 | OFFICE EXPENSE | | | | | |
| V | 63 | OFFICE EXPENSE | | | | | |
| V | 64 | OFFICE EXPENSE | | | | | |
| V | 65 | OFFICE EXPENSE | | | | | |
| V | 66 | OFFICE EXPENSE | | | | | |
| V | 67 | OFFICE EXPENSE | | | | | |
| V | 68 | OFFICE EXPENSE | | | | | |
| V | 69 | OFFICE EXPENSE | | | | | |
| V | 70 | OFFICE EXPENSE | | | | | |
| V | 71 | OFFICE EXPENSE | | | | | |
| V | 72 | OFFICE EXPENSE | | | | | |
| V | 73 | OFFICE EXPENSE | | | | | |
| V | 74 | OFFICE EXPENSE | | | | | |
| V | 75 | OFFICE EXPENSE | | | | | |
| V | 76 | OFFICE EXPENSE | | | | | |
| V | 77 | OFFICE EXPENSE | | | | | |
| V | 78 | OFFICE EXPENSE | | | | | |
| V | 79 | OFFICE EXPENSE | | | | | |
| V | 80 | OFFICE EXPENSE | | | | | |
| V | 81 | OFFICE EXPENSE | | | | | |
| V | 82 | OFFICE EXPENSE | | | | | |
| V | 83 | OFFICE EXPENSE | | | | | |
| V | 84 | OFFICE EXPENSE | | | | | |
| V | 85 | OFFICE EXPENSE | | | | | |
| V | 86 | OFFICE EXPENSE | | | | | |
| V | 87 | OFFICE EXPENSE | | | | | |
| V | 88 | OFFICE EXPENSE | | | | | |
| V | 89 | OFFICE EXPENSE | | | | | |
| V | 90 | OFFICE EXPENSE | | | | | |
| V | 91 | OFFICE EXPENSE | | | | | |
| V | 92 | OFFICE EXPENSE | | | | | |
| V | 93 | OFFICE EXPENSE | | | | | |
| V | 94 | OFFICE EXPENSE | | | | | |
| V | 95 | OFFICE EXPENSE | | | | | |
| V | 96 | OFFICE EXPENSE | | | | | |
| V | 97 | OFFICE EXPENSE | | | | | |
| V | 98 | OFFICE EXPENSE | | | | | |
| V | 99 | OFFICE EXPENSE | | | | | |
| V | 100 | OFFICE EXPENSE | | | | | |
| V | 101 | OFFICE EXPENSE | | | | | |
| V | 102 | OFFICE EXPENSE | | | | | |
| V | 103 | OFFICE EXPENSE | | | | | |
| V | 104 | OFFICE EXPENSE | | | | | |
| V | 105 | OFFICE EXPENSE | | | | | |
| V | 106 | OFFICE EXPENSE | | | | | |
| V | 107 | OFFICE EXPENSE | | | | | |
| V | 108 | OFFICE EXPENSE | | | | | |
| V | 109 | OFFICE EXPENSE | | | | | |
| V | 110 | OFFICE EXPENSE | | | | | |
| V | 111 | OFFICE EXPENSE | | | | | |
| V | 112 | OFFICE EXPENSE | | | | | |
| V | 113 | OFFICE EXPENSE | | | | | |
| V | 114 | OFFICE EXPENSE | | | | | |
| V | 115 | OFFICE EXPENSE | | | | | |
| V | 116 | OFFICE EXPENSE | | | | | |
| V | 117 | OFFICE EXPENSE | | | | | |
| V | 118 | OFFICE EXPENSE | | | | | |
| V | 119 | OFFICE EXPENSE | | | | | |
| V | 120 | OFFICE EXPENSE | | | | | |
| V | 121 | OFFICE EXPENSE | | | | | |
| V | 122 | OFFICE EXPENSE | | | | | |
| V | 123 | OFFICE EXPENSE | | | | | |
| V | 124 | OFFICE EXPENSE | | | | | |
| V | 125 | OFFICE EXPENSE | | | | | |
| V | 126 | OFFICE EXPENSE | | | | | |
| V | 127 | OFFICE EXPENSE | | | | | |
| V | 128 | OFFICE EXPENSE | | | | | |
| V | 129 | OFFICE EXPENSE | | | | | |
| V | 130 | OFFICE EXPENSE | | | | | |
| V | 131 | OFFICE EXPENSE | | | | | |
| V | 132 | OFFICE EXPENSE | | | | | |
| V | 133 | OFFICE EXPENSE | | | | | |
| V | 134 | OFFICE EXPENSE | | | | | |
| V | 135 | OFFICE EXPENSE | | | | | |
| V | 136 | OFFICE EXPENSE | | | | | |
| V | 137 | OFFICE EXPENSE | | | | | |
| V | 138 | OFFICE EXPENSE | | | | | |
| V | 139 | OFFICE EXPENSE | | | | | |
| V | 140 | OFFICE EXPENSE | | | | | |
| V | 141 | OFFICE EXPENSE | | | | | |
| V | 142 | OFFICE EXPENSE | | | | | |
| V | 143 | OFFICE EXPENSE | | | | | |
| V | 144 | OFFICE EXPENSE | | | | | |
| V | 145 | OFFICE EXPENSE | | | | | |
| V | 146 | OFFICE EXPENSE | | | | | |
| V | 147 | OFFICE EXPENSE | | | | | |
| V | 148 | OFFICE EXPENSE | | | | | |
| V | 149 | OFFICE EXPENSE | | | | | |
| V | 150 | OFFICE EXPENSE | | | | | |
| V | 151 | OFFICE EXPENSE | | | | | |
| V | 152 | OFFICE EXPENSE | | | | | |
| V | 153 | OFFICE EXPENSE | | | | | |
| V | 154 | OFFICE EXPENSE | | | | | |
| V | 155 | OFFICE EXPENSE | | | | | |
| V | 156 | OFFICE EXPENSE | | | | | |
| V | 157 | OFFICE EXPENSE | | | | | |
| V | 158 | OFFICE EXPENSE | | | | | |
| V | 159 | OFFICE EXPENSE | | | | | |
| V | 160 | OFFICE EXPENSE | | | | | |
| V | 161 | OFFICE EXPENSE | | | | | |
| V | 162 | OFFICE EXPENSE | | | | | |
| V | 163 | OFFICE EXPENSE | | | | | |
| V | 164 | OFFICE EXPENSE | | | | | |
| V | 165 | OFFICE EXPENSE | | | | | |
| V | 166 | OFFICE EXPENSE | | | | | |
| V | 167 | OFFICE EXPENSE | | | | | |
| V | 168 | OFFICE EXPENSE | | | | | |
| V | 169 | OFFICE EXPENSE | | | | | |
| V | 170 | OFFICE EXPENSE | | | | | |
| V | 171 | OFFICE EXPENSE | | | | | |
| V | 172 | OFFICE EXPENSE | | | | | |
| V | 173 | OFFICE EXPENSE | | | | | |
| V | 174 | OFFICE EXPENSE | | | | | |
| V | 175 | OFFICE EXPENSE | | | | | |
| V | 176 | OFFICE EXPENSE | | | | | |
| V | 177 | OFFICE EXPENSE | | | | | |
| V | 178 | OFFICE EXPENSE | | | | | |
| V | 179 | OFFICE EXPENSE | | | | | |
| V | 180 | OFFICE EXPENSE | | | | | |
| V | 181 | OFFICE EXPENSE | | | | | |
| V | 182 | OFFICE EXPENSE | | | | | |
| V | 183 | OFFICE EXPENSE | | | | | |
| V | 184 | OFFICE EXPENSE | | | | | |
| V | 185 | OFFICE EXPENSE | | | | | |
| V | 186 | OFFICE EXPENSE | | | | | |
| V | 187 | OFFICE EXPENSE | | | | | |
| V | 188 | OFFICE EXPENSE | | | | | |
| V | 189 | OFFICE EXPENSE | | | | | |
| V | 190 | OFFICE EXPENSE | | | | | |
| V | 191 | OFFICE EXPENSE | | | | | |
| V | 192 | OFFICE EXPENSE | | | | | |
| V | 193 | OFFICE EXPENSE | | | | | |
| V | 194 | OFFICE EXPENSE | | | | | |
| V | 195 | OFFICE EXPENSE | | | | | |
| V | 196 | OFFICE EXPENSE | | | | | |
| V | 197 | OFFICE EXPENSE | | | | | |
| V | 198 | OFFICE EXPENSE | | | | | |
| V | 199 | OFFICE EXPENSE | | | | | |
| V | 200 | OFFICE EXPENSE | | | | | |
| V | 201 | OFFICE EXPENSE | | | | | |
| V | 202 | OFFICE EXPENSE | | | | | |
| V | 203 | OFFICE EXPENSE | | | | | |
| V | 204 | OFFICE EXPENSE | | | | | |
| V | 205 | OFFICE EXPENSE | | | | | |
| V | 206 | OFFICE EXPENSE | | | | | |
| V | 207 | OFFICE EXPENSE | | | | | |
| V | 208 | OFFICE EXPENSE | | | | | |
| V | 209 | OFFICE EXPENSE | | | | | |
| V | 210 | OFFICE EXPENSE | | | | | |
| V | 211 | OFFICE EXPENSE | | | | | |
| V | 212 | OFFICE EXPENSE | | | | | |
| V | 213 | OFFICE EXPENSE | | | | | |
| V | 214 | OFFICE EXPENSE | | | | | |
| V | 215 | OFFICE EXPENSE | | | | | |
| V | 216 | OFFICE EXPENSE | | | | | |
| V | 217 | OFFICE EXPENSE | | | | | |
| V | 218 | OFFICE EXPENSE | | | | | |
| V | 219 | OFFICE EXPENSE | | | | | |
| V | 220 | OFFICE EXPENSE | | | | | |
| V | 221 | OFFICE EXPENSE | | | | | |
| V | 222 | OFFICE EXPENSE | | | | | |
| V | 223 | OFFICE EXPENSE | | | | | |
| V | 224 | OFFICE EXPENSE | | | | | |
| V | 225 | OFFICE EXPENSE | | | | | |
| V | 226 | OFFICE EXPENSE | | | | | |
| V | 227 | OFFICE EXPENSE | | | | | |
| V | 228 | OFFICE EXPENSE | | | | | |
| V | 229 | OFFICE EXPENSE | | | | | |
| V | 230 | OFFICE EXPENSE | | | | | |
| V | 231 | OFFICE EXPENSE | | | | | |
| V | 232 | OFFICE EXPENSE | | | | | |
| V | 233 | OFFICE EXPENSE | | | | | |
| V | 234 | OFFICE EXPENSE | | | | | |
| V | 235 | OFFICE EXPENSE | | | | | |
| V | 236 | OFFICE EXPENSE | | | | | |
| V | 237 | OFFICE EXPENSE | | | | | |
| V | 238 | OFFICE EXPENSE | | | | | |
| V | 239 | OFFICE EXPENSE | | | | | |
| V | 240 | OFFICE EXPENSE | | | | | |
| V | 241 | OFFICE EXPENSE | | | | | |
| V | 242 | OFFICE EXPENSE | | | | | |
| V | 243 | OFFICE EXPENSE | | | | | |
| V | 244 | OFFICE EXPENSE | | | | | |
| V | 245 | OFFICE EXPENSE | | | | | |
| V | 246 | OFFICE EXPENSE | | | | | |
| V | 247 | OFFICE EXPENSE | | | | | |
| V | 248 | OFFICE EXPENSE | | | | | |
| V | 249 | OFFICE EXPENSE | | | | | |
| V | 250 | OFFICE EXPENSE | | | | | |
| V | 251 | OFFICE EXPENSE | | | | | |
| V | 252 | OFFICE EXPENSE | | | | | |
| V | 253 | OFFICE EXPENSE | | | | | |
| V | 254 | OFFICE EXPENSE | | | | | |
| V | 255 | OFFICE EXPENSE | | | | | |
| V | 256 | OFFICE EXPENSE | | | | | |
| V | 257 | OFFICE EXPENSE | | | | | |
| V | 258 | OFFICE EXPENSE | | | | | |
| V | 259 | OFFICE EXPENSE | | | | | |
| V | 260 | OFFICE EXPENSE | | | | | |
| V | 261 | OFFICE EXPENSE | | | | | |
| V | 262 | OFFICE EXPENSE | | | | | |
| V | 263 | OFFICE EXPENSE | | | | | |
| V | 264 | OFFICE EXPENSE | | | | | |
| V | 265 | OFFICE EXPENSE | | | | | |
| V | 266 | OFFICE EXPENSE | | | | | |
| V | 267 | OFFICE EXPENSE | | | | | |
| V | 268 | | | | | | |

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: |
|------------|-------|---------------------------|-----------|--------------------------------|----------------------|--|--|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) |
| 15 | V | 21 BOOKKEEPING FEES | \$ 92,031 | EKS MANAGEMENT, INC. | | \$ | \$ (92,031) |
| 16 | V | | | | | | |
| 17 | V | | | | | | |
| 18 | V | 6 PAINTING SALARIES | | | | 1,794 | 1,794 |
| 19 | V | 10 RN CONSULTANT SALARIES | | | | 1,070 | 1,070 |
| 20 | V | 19 PROFESSIONAL FEES | | | | 13,203 | 13,203 |
| 21 | V | 20 WAST ADS | | | | 254 | 254 |
| 22 | V | 21 OFFICE EXPENSE | | | | 24,847 | 24,847 |
| 23 | V | 23 SEMINARS | | | | 70 | 70 |
| 24 | V | 25 TRANSPORTATION | | | | 178 | 178 |
| 25 | V | 26 INSURANCE | | | | 886 | 886 |
| 26 | V | 27 EMPLOYEE BENEFITS | | | | 5,450 | 5,450 |
| 27 | V | 30 DEPRECIATION | | | | 524 | 524 |
| 28 | V | 35 EQUIPMENT RENT | | | | 2,856 | 2,856 |
| 29 | V | | | | | | |
| 30 | V | | | | | | |
| 31 | V | | | | | | |
| 32 | V | | | | | | |
| 33 | V | | | | | | |
| 34 | V | | | | | | |
| 35 | V | | | | | | |
| 36 | V | | | | | | |
| 37 | V | | | | | | |
| 38 | V | | | | | | |
| 39 | Total | | \$ 92,031 | | | \$ 51,132 | \$ * (40,899) |

Sum_6A

-92031

1794

1070

13203

254

24847

70

178

886

5450

524

2856

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Facility Name & ID Number KANKAKEE TERRACE # 0022897 Report Period Beginnin 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: |
|------------|-------|---------------------------|----------|--------------------------------|----------------------|--|--|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) |
| 15 | V | 36 OFFICE RENT | \$ 9,450 | IME REALTY CORP | | \$ | \$ (9,450) |
| 16 | V | | | | | | |
| 17 | V | | | | | | |
| 18 | V | 5 UTILITIES | | | | 79 | 79 |
| 19 | V | 6 REPAIRS & MAINTENANCE | | | | 746 | 746 |
| 20 | V | 19 PROFESSIONAL FEES | | | | 74 | 74 |
| 21 | V | 21 OFFICE EXPENSE | | | | 49 | 49 |
| 22 | V | 26 INSURANCE | | | | 71 | 71 |
| 23 | V | 30 DEPRECIATION | | | | 781 | 781 |
| 24 | V | 32 INTEREST | | | | 1,481 | 1,481 |
| 25 | V | 33 RE TAX | | | | 1,502 | 1,502 |
| 26 | V | | | | | | |
| 27 | V | | | | | | |
| 28 | V | | | | | | |
| 29 | V | | | | | | |
| 30 | V | | | | | | |
| 31 | V | | | | | | |
| 32 | V | | | | | | |
| 33 | V | | | | | | |
| 34 | V | | | | | | |
| 35 | V | | | | | | |
| 36 | V | | | | | | |
| 37 | V | | | | | | |
| 38 | V | | | | | | |
| 39 | Total | | \$ 9,450 | | | \$ 4,783 | \$ * (4,667) |

Sum_6B

-9450

79

746

74

49

71

781

1481

1502

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number KANKAKEE TERRACE

0022897

Report Period Beginn 01/01/2000 Ending: 12/31/2000

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) |
| 15 | V | | \$ | | | \$ | \$ |
| 16 | V | | | | | | |
| 17 | V | | | | | | |
| 18 | V | | | | | | |
| 19 | V | | | | | | |
| 20 | V | | | | | | |
| 21 | V | | | | | | |
| 22 | V | | | | | | |
| 23 | V | | | | | | |
| 24 | V | | | | | | |
| 25 | V | | | | | | |
| 26 | V | | | | | | |
| 27 | V | | | | | | |
| 28 | V | | | | | | |
| 29 | V | | | | | | |
| 30 | V | | | | | | |
| 31 | V | | | | | | |
| 32 | V | | | | | | |
| 33 | V | | | | | | |
| 34 | V | | | | | | |
| 35 | V | | | | | | |
| 36 | V | | | | | | |
| 37 | V | | | | | | |
| 38 | V | | | | | | |
| 39 | Total | | \$ | | | \$ | \$ * |

Sum_6C

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

| 1 | 2 | 3 Cost Per General Ledger | 4 | 5 Cost to Related Organization | 6 | 7 | 8 Difference: |
|------------|-------|---------------------------|--------|--------------------------------|----------------------|--|--|
| Schedule V | Line | Item | Amount | Name of Related Organization | Percent of Ownership | Operating Cost of Related Organization | Adjustments for Related Organization Costs (7 minus 4) |
| 15 | V | | \$ | | | \$ | \$ |
| 16 | V | | | | | | |
| 17 | V | | | | | | |
| 18 | V | | | | | | |
| 19 | V | | | | | | |
| 20 | V | | | | | | |
| 21 | V | | | | | | |
| 22 | V | | | | | | |
| 23 | V | | | | | | |
| 24 | V | | | | | | |
| 25 | V | | | | | | |
| 26 | V | | | | | | |
| 27 | V | | | | | | |
| 28 | V | | | | | | |
| 29 | V | | | | | | |
| 30 | V | | | | | | |
| 31 | V | | | | | | |
| 32 | V | | | | | | |
| 33 | V | | | | | | |
| 34 | V | | | | | | |
| 35 | V | | | | | | |
| 36 | V | | | | | | |
| 37 | V | | | | | | |
| 38 | V | | | | | | |
| 39 | Total | | \$ | | | \$ | \$ * |

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

| | 1 Name | 2 Title | 3 Function | 4 Ownership Interest | 5 Compensation Received From Other Nursing Homes* | 6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week | | 7 Compensation Included in Costs for this Reporting Period** | | 8 Schedule V. Line & Column Reference | |
|----|-----------------|--------------|----------------|-------------------------|--|--|---------|---|-----------|--|----|
| | | | | | | Hours | Percent | Description | Amount | | |
| 1 | BERNARD COHEN | GENERAL PART | ADMINISTRATION | | SCHEDULE ATTACHED | | | CONSULT | \$ 21,000 | 17-3 | 1 |
| 2 | MORRIS ESFORMES | GENERAL PART | ADMINISTRATION | | | | | SALARY | 14,284 | 17-7 | 2 |
| 3 | | | | | | | | | | | 3 |
| 4 | | | | | | | | | | | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | TOTAL | \$ 35,284 | | 13 |

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REI

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Print Preview

| the name(s)
PORTS.

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897** Report Period Beginning: **01/01/2000**Ending: **1/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

Show Pgs 8A thru 8

Show Pgs 8E thru 8

Hide Pgs 8A thru 8

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **EMI ENTERPRISES, INC.**Street Address **3737 W. ARTHUR**City / State / Zip Code **LINCOLNWOOD, IL 60712**Phone Number **(847) 674 - 1946**Fax Number **(847) 674 - 1962**

B. Show the allocation of costs below. If necessary, please attach worksheets.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | | |
|---------------------------------|--------|---|--------------|--|---|---|-------------------|------------------------------------|-----------|----|
| Schedule V Line Reference | Item | Unit of Allocation (i.e.,Days, Direct Cost Square Feet) | Total Units | Number of Subunits Being Allocated Among | Total Indirect Cost Being Allocated | Amount of Salary Cost Contained in Column 6 | Facility Units | Allocation (col.8/col.4)x col.6 | | |
| 1 | 17 | OFFICERS SALARY | PATIENT DAYS | 617,052 | 11 | \$ 185,000 | \$ 185,000 | 47,644 | \$ 14,284 | 1 |
| 2 | 19 | ACCOUNTING FEES | PATIENT DAYS | 617,052 | 11 | 6,053 | 47,644 | 467 | | 2 |
| 3 | 21 | OFFICE EXPENSE | PATIENT DAYS | 617,052 | 11 | 84,917 | 64,123 | 47,644 | 6,557 | 3 |
| 4 | 25 | TRANSPORTATION | PATIENT DAYS | 617,052 | 11 | 4,810 | 47,644 | 371 | | 4 |
| 5 | 26 | INSURANCE | PATIENT DAYS | 617,052 | 11 | 4,462 | 47,644 | 345 | | 5 |
| 6 | 27 | EMPLOYEE BENEFITS | PATIENT DAYS | 617,052 | 11 | 34,099 | 47,644 | 2,633 | | 6 |
| 7 | 30 | DEPRECIATION | PATIENT DAYS | 617,052 | 11 | 2,964 | 47,644 | 229 | | 7 |
| 8 | 35 | AUTO LEASE | PATIENT DAYS | 617,052 | 11 | 21,677 | 47,644 | 1,674 | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ 343,982 | \$ 249,123 | | \$ 26,560 | 25 |

Print Preview

Facility Name & ID Number KANKAKEE TERRACE# 0022897 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization EKS MGMT,Street Address 3737 W. ARTHURCity / State / Zip Code LINCOLNWOOD, IL 60712Phone Number (847) 674 - 1946Fax Number (847) 674 - 1962

| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|----|---------------------------------|----------------------|--|-------------|--|---|---|-------------------|------------------------------------|----|
| | Schedule V Line Reference | Item | Unit of Allocation (i.e., Days, Direct Cost Square Feet) | Total Units | Number of Subunits Being Allocated Among | Total Indirect Cost Being Allocated | Amount of Salary Cost Contained in Column 6 | Facility Units | Allocation (col.8/col.4)x col.6 | |
| 1 | 6 | PAINTING SALARIES | PATIENT DAYS | 617,052 | 11 | \$ 23,229 | \$ 23,229 | 47,644 | \$ 1,794 | 1 |
| 2 | 10 | RN CONSULTANT SALARY | PATIENT DAYS | 617,052 | 11 | 13,856 | 13,856 | 47,644 | 1,070 | 2 |
| 3 | 19 | PROFESSIONAL FEES | PATIENT DAYS | 617,052 | 11 | 170,994 | 131,341 | 47,644 | 13,203 | 3 |
| 4 | 20 | WANT ADS | PATIENT DAYS | 617,052 | 11 | 3,290 | | 47,644 | 254 | 4 |
| 5 | 21 | OFFICE EXPENSE | PATIENT DAYS | 617,052 | 11 | 321,801 | 269,147 | 47,644 | 24,847 | 5 |
| 6 | 23 | SEMINARS | PATIENT DAYS | 617,052 | 11 | 905 | | 47,644 | 70 | 6 |
| 7 | 25 | TRANSPORTATION | PATIENT DAYS | 617,052 | 11 | 2,302 | | 47,644 | 178 | 7 |
| 8 | 26 | INSURANCE | PATIENT DAYS | 617,052 | 11 | 11,476 | | 47,644 | 886 | 8 |
| 9 | 27 | EMPLOYEE BENEFITS | PATIENT DAYS | 617,052 | 11 | 70,589 | | 47,644 | 5,450 | 9 |
| 10 | 30 | DEPRECIATION | PATIENT DAYS | 617,052 | 11 | 6,797 | | 47,644 | 524 | 10 |
| 11 | 35 | EQUIPMENT RENT | PATIENT DAYS | 617,052 | 11 | 36,988 | | 47,644 | 2,856 | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ 662,227 | \$ 437,573 | | \$ 51,132 | 25 |

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897** Report Period Beginning: **01/01/2000**Ending: **12/31/2000**

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization **IME REALTY CORP.**Street Address **3737 W. ARTHUR**City / State / Zip Code **LINCOLNWOOD, IL 60712**Phone Number **(847) 674 - 1946**Fax Number **(847) 674 - 1962**

B. Show the allocation of costs below. If necessary, please attach worksheets.

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e., Days, Direct Cost Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|-----------------------|---|------------------|---|--|--|------------------------|---|----|
| 1 | 5 | UTILITIES | INCOME | 100 | 11 | \$ 1,685 | \$ | 5 | \$ 79 | 1 |
| 2 | 6 | REPAIRS & MAINTENANCE | INCOME | 100 | 11 | 15,902 | | 5 | 746 | 2 |
| 3 | 19 | PROFESSIONAL FEES | INCOME | 100 | 11 | 1,575 | | 5 | 74 | 3 |
| 4 | 21 | OFFICE EXPENSE | INCOME | 100 | 11 | 1,047 | | 5 | 49 | 4 |
| 5 | 26 | INSURANCE | INCOME | 100 | 11 | 1,504 | | 5 | 71 | 5 |
| 6 | 30 | DEPRECIATION | INCOME | 100 | 11 | 16,647 | | 5 | 781 | 6 |
| 7 | 32 | INTEREST | INCOME | 100 | 11 | 31,549 | | 5 | 1,481 | 7 |
| 8 | 33 | RE TAX | INCOME | 100 | 11 | 32,000 | | 5 | 1,502 | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
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| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ 101,909 | \$ | | \$ 4,783 | 25 |

Facility Name & ID Number KANKAKEE TERRACE# 0022897 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

| 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | |
|---------------------------------|--------|--|-------------|--|---|---|-------------------|------------------------------------|----|
| Schedule V Line Reference | Item | Unit of Allocation (i.e., Days, Direct Cost Square Feet) | Total Units | Number of Subunits Being Allocated Among | Total Indirect Cost Being Allocated | Amount of Salary Cost Contained in Column 6 | Facility Units | Allocation (col.8/col.4)x col.6 | |
| 1 | | | | | \$ | \$ | | \$ | 1 |
| 2 | | | | | | | | | 2 |
| 3 | | | | | | | | | 3 |
| 4 | | | | | | | | | 4 |
| 5 | | | | | | | | | 5 |
| 6 | | | | | | | | | 6 |
| 7 | | | | | | | | | 7 |
| 8 | | | | | | | | | 8 |
| 9 | | | | | | | | | 9 |
| 10 | | | | | | | | | 10 |
| 11 | | | | | | | | | 11 |
| 12 | | | | | | | | | 12 |
| 13 | | | | | | | | | 13 |
| 14 | | | | | | | | | 14 |
| 15 | | | | | | | | | 15 |
| 16 | | | | | | | | | 16 |
| 17 | | | | | | | | | 17 |
| 18 | | | | | | | | | 18 |
| 19 | | | | | | | | | 19 |
| 20 | | | | | | | | | 20 |
| 21 | | | | | | | | | 21 |
| 22 | | | | | | | | | 22 |
| 23 | | | | | | | | | 23 |
| 24 | | | | | | | | | 24 |
| 25 | TOTALS | | | | \$ | \$ | | \$ | 25 |

Facility Name & ID Number KANKAKEE TERRACE# 0022897 Report Period Beginning: 01/01/2000Ending: 12/31/2000

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

| | 1 Schedule V Line Reference | 2 Item | 3 Unit of Allocation (i.e., Days, Direct Cost Square Feet) | 4 Total Units | 5 Number of Subunits Being Allocated Among | 6 Total Indirect Cost Being Allocated | 7 Amount of Salary Cost Contained in Column 6 | 8 Facility Units | 9 Allocation (col.8/col.4)x col.6 | |
|----|--------------------------------------|---------------|---|------------------|---|--|--|------------------------|---|----|
| 1 | | | | | | \$ | \$ | | | 1 |
| 2 | | | | | | | | | | 2 |
| 3 | | | | | | | | | | 3 |
| 4 | | | | | | | | | | 4 |
| 5 | | | | | | | | | | 5 |
| 6 | | | | | | | | | | 6 |
| 7 | | | | | | | | | | 7 |
| 8 | | | | | | | | | | 8 |
| 9 | | | | | | | | | | 9 |
| 10 | | | | | | | | | | 10 |
| 11 | | | | | | | | | | 11 |
| 12 | | | | | | | | | | 12 |
| 13 | | | | | | | | | | 13 |
| 14 | | | | | | | | | | 14 |
| 15 | | | | | | | | | | 15 |
| 16 | | | | | | | | | | 16 |
| 17 | | | | | | | | | | 17 |
| 18 | | | | | | | | | | 18 |
| 19 | | | | | | | | | | 19 |
| 20 | | | | | | | | | | 20 |
| 21 | | | | | | | | | | 21 |
| 22 | | | | | | | | | | 22 |
| 23 | | | | | | | | | | 23 |
| 24 | | | | | | | | | | 24 |
| 25 | TOTALS | | | | | \$ | \$ | | \$ | 25 |

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

| | 1 | 2 | | 3 | 4 | 5 | 6 | | 7 | 8 | 9 | 10 | |
|----|--|-----------|----|---------------------|--------------------------|--------------|----------------|--------------|---------------|--------------------------|-----------------------------------|----|--|
| | Name of Lender | Related** | | Purpose of Loan | Monthly Payment Required | Date of Note | Amount of Note | | Maturity Date | Interest Rate (4 Digits) | Reporting Period Interest Expense | | |
| | | YES | NO | | | | Original | Balance | | | | | |
| | A. Directly Facility Related Long-Term | | | | | | | | | | | | |
| 1 | LASALLE BANK | | X | MORTGAGE | \$8,069.00 | 08/01/95 | \$ 2,800,000 | \$ 2,340,063 | 07/03/15 | PRIME+ | \$ 156,359 | 1 | |
| 2 | LASALLE BANK | | X | LETTER OF CREDIT | | | | | | | 37,218 | 2 | |
| 3 | | | | | | | | | | | | 3 | |
| 4 | | | | | | | | | | | | 4 | |
| 5 | | | | | | | | | | | | 5 | |
| | Working Capital | | | | | | | | | | | | |
| 6 | CORUS BANK | | X | LINE OF CREDIT | | | 805,000 | 760,000 | | PRIME+ | 60,626 | 6 | |
| 7 | INSURANCE FINANCING | | X | INSURANCE FINANCING | | | | | | PRIME+ | 874 | 7 | |
| 8 | | | | | | | | | | | | 8 | |
| 9 | TOTAL Facility Related | | | | \$8,069.00 | | \$ 3,605,000 | \$ 3,100,063 | | | \$ 255,077 | 9 | |
| | B. Non-Facility Related* | | | | | | | | | | | | |
| 10 | | | | | | | | | | | | 10 | |
| 11 | | | | | | | | | | | | 11 | |
| 12 | | | | | | | | | | | | 12 | |
| 13 | | | | | | | | | | | | 13 | |
| 14 | TOTAL Non-Facility Related | | | | | | \$ | \$ | | | \$ | 14 | |
| 15 | TOTALS (line 9+line14) | | | | | | \$ 3,605,000 | \$ 3,100,063 | | | \$ 255,077 | 15 | |

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.

(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.

(See instructions.)

Print Preview

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

| | | | |
|--|----|---------------|---|
| 1. Real Estate Tax accrual used on 1999 report. | \$ | 46,600 | 1 |
| 2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.) | \$ | 45,914 | 2 |
| 3. Under or (over) accrual (line 2 minus line 1). | \$ | (686) | 3 |
| 4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.) | \$ | 46,400 | 4 |
| 5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.) | \$ | | 5 |
| 6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.) | \$ | | 6 |
| 7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6 | \$ | 45,714 | 7 |

Real Estate Tax History:

| | | | | | |
|---|------|---------------|----|--|--|
| Real Estate Tax Bill for Calendar Year: | 1995 | 40,896 | 8 | | |
| | 1996 | 42,638 | 9 | | |
| | 1997 | 47,494 | 10 | | |
| | 1998 | 46,150 | 11 | | |
| | 1999 | 45,914 | 12 | | |

| | | | |
|---|-------------------------|--------------------------------------|----|
| | FOR OFF USE ONLY | | |
| | 13 | FROM R. E. TAX STATEMENT FOR 1999 \$ | 13 |
| | 14 | PLUS APPEAL COST FROM LINE 5 \$ | 14 |
| THE CURRENT YEAR REAL ESTATE TAX ACCRUAL IS BASED ON ~ 101% OF THE PRIOR YEAR REAL ESTATE TAX BILL | 15 | LESS REFUND FROM LINE 6 \$ | 15 |
| THE PAYMENT ON LINE 2 APPLIES TO THE 1999 TAX YEAR. | 16 | AMOUNT TO USE FOR RATE CALCULATIC \$ | 16 |

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

Print Preview

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,663 B. General Construction Type: Exterior BRICK Frame Number of Stories

C. Does the Operating Entity? ☒ (a) Own the Facility ☐ (b) Rent from a Related Organization. ☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? ☒ (a) Own the Equipment ☐ (b) Rent equipment from a Related Organization. ☒ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? ☐ YES ☒ NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

| | 1 | 2 | 3 | 4 | |
|---|--------------|-------------|---------------|------------|---|
| | Use | Square Feet | Year Acquired | Cost | |
| 1 | NURSING HOME | | 1976 | \$ 100,000 | 1 |
| 2 | | | | | 2 |
| 3 | TOTALS | | | \$ 100,000 | 3 |

Print Preview

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Show Pgs 12A & 12

Show Pgs 12C and 12

Hide Pgs 12A thru 12

STATE OF ILLINOIS

Page 12

Facility Name & ID Number KANKAKEE TERRACE

0022897

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|----|-----------------------------------|------------------|-----------------------|--------------------------|--------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 4 | 118 | | 1976 | 1972 | \$ 1,233,000 | \$ 49,320 | 25 | \$ 49,320 | | \$ 1,220,670 | 4 |
| 5 | | | | 1982 | | | | | | | 5 |
| 6 | 10 | | | 1998 | 981,636 | 25,169 | 39 | 25,169 | | 63,992 | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | REL PARTY | | | | | 1,534 | | 1,534 | | | 8 |
| 9 | Improvement Type** | | | | | | | | | | |
| 9 | BUILDING IMPROVEMENTS | | | 1978-80 | 8,584 | 0 | 10 | | | 8,584 | 9 |
| 10 | BUILDING IMPROVEMENTS | | | 1981 | 8,060 | 0 | 15 | | | 8,060 | 10 |
| 11 | BUILDING IMPROVEMENTS | | | 1981 | 51,503 | 1,635 | 31.5 | 1,635 | | 21,187 | 11 |
| 12 | BUILDING IMPROVEMENTS | | | 1987 | 7,400 | 235 | 10 | 740 | 505 | 8,880 | 12 |
| 13 | BUILDING IMPROVEMENTS | | | 1988 | 17,500 | 556 | 15 | 1,167 | 611 | 14,685 | 13 |
| 14 | BUILDING IMPROVEMENTS | | | 1990 | 27,632 | 877 | 20 | 1,382 | 505 | 14,511 | 14 |
| 15 | BUILDING IMPROVEMENTS | | | 1991 | 12,763 | 406 | 20 | 638 | 232 | 6,061 | 15 |
| 16 | BUILDING IMPROVEMENTS | | | 1992 | 36,068 | 1,145 | 31.5 | 1,145 | | 9,592 | 16 |
| 17 | BUILDING IMPROVEMENTS | | | 1993 | 40,178 | 1,253 | 31.5 | 1,276 | 23 | 9,778 | 17 |
| 18 | BUILDING IMPROVEMENTS | | | 1994 | 18,233 | 467 | 39 | 467 | | 3,107 | 18 |
| 19 | CARPET | | | 1996 | 8,028 | 206 | 39 | 206 | | 901 | 19 |
| 20 | SHADE STRUCTURE | | | 1997 | 2,200 | 56 | 39 | 56 | | 203 | 20 |
| 21 | CONCRETE SLAB | | | 1997 | 667 | 17 | 39 | 17 | | 60 | 21 |
| 22 | NURSE STATION | | | 1998 | 4,950 | 127 | 39 | 127 | | 414 | 22 |
| 23 | ROOFTOP AC | | | 1998 | 2,031 | 52 | 39 | 52 | | 130 | 23 |
| 24 | PARKING LOT | | | 1999 | 18,460 | 1,231 | 15 | 1,231 | | 1,846 | 24 |
| 25 | ROOFTOP AC | | | 1999 | 6,716 | 172 | 39 | 172 | | 300 | 25 |
| 26 | DOORS | | | 1999 | 2,151 | 55 | 39 | 55 | | 67 | 26 |
| 27 | CARPET | | | 1999 | 14,114 | 362 | 39 | 362 | | 407 | 27 |
| 28 | DRAPERIES & RODS/REPLACE SHINGLES | | | 2000 | 7,865 | 1,124 | 20 | 197 | (927) | 197 | 28 |
| 29 | LANDSCAPE RENOVATION | | | 2000 | 6,700 | 223 | 15 | 223 | | 223 | 29 |
| 30 | VINYL/CERAMIC TILE | | | 2000 | 1,941 | 56 | 27.5 | 56 | | 56 | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | TOTAL (lines 4 thru 35) | | | | \$ 2518380 | \$ 86,278 | | \$ 87,227 | \$ 949 | \$ 1,393,911 | 36 |

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12A

Facility Name & ID Numbe KANKAKEE TERRACE

0022897

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|----|--|------------------|-----------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 4 | | | | | \$ | \$ | | \$ | \$ | \$ | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | | | | | | | |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | 13 |
| 14 | | | | | | | | | | | 14 |
| 15 | | | | | | | | | | | 15 |
| 16 | | | | | | | | | | | 16 |
| 17 | | | | | | | | | | | 17 |
| 18 | | | | | | | | | | | 18 |
| 19 | | | | | | | | | | | 19 |
| 20 | | | | | | | | | | | 20 |
| 21 | | | | | | | | | | | 21 |
| 22 | | | | | | | | | | | 22 |
| 23 | | | | | | | | | | | 23 |
| 24 | | | | | | | | | | | 24 |
| 25 | | | | | | | | | | | 25 |
| 26 | | | | | | | | | | | 26 |
| 27 | | | | | | | | | | | 27 |
| 28 | | | | | | | | | | | 28 |
| 29 | | | | | | | | | | | 29 |
| 30 | | | | | | | | | | | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | \$ #VALUE! | \$ | | \$ | \$ | \$ | 36 |

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12B

Facility Name & ID Numbe KANKAKEE TERRACE

0022897

Report Period Beginning:

01/01/200(Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|----|--|------------------|-----------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 4 | | | | | \$ | \$ | | \$ | \$ | \$ | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | | | | | | | |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | 13 |
| 14 | | | | | | | | | | | 14 |
| 15 | | | | | | | | | | | 15 |
| 16 | | | | | | | | | | | 16 |
| 17 | | | | | | | | | | | 17 |
| 18 | | | | | | | | | | | 18 |
| 19 | | | | | | | | | | | 19 |
| 20 | | | | | | | | | | | 20 |
| 21 | | | | | | | | | | | 21 |
| 22 | | | | | | | | | | | 22 |
| 23 | | | | | | | | | | | 23 |
| 24 | | | | | | | | | | | 24 |
| 25 | | | | | | | | | | | 25 |
| 26 | | | | | | | | | | | 26 |
| 27 | | | | | | | | | | | 27 |
| 28 | | | | | | | | | | | 28 |
| 29 | | | | | | | | | | | 29 |
| 30 | | | | | | | | | | | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | \$ #VALUE! | \$ | | \$ | \$ | \$ | 36 |

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

0022897

Report Period Beginning:

Page 12C

01/01/200(Ending: 12/31/2000

Facility Name & ID Numbe **KANKAKEE TERRACE**

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|----|--|------------------|-----------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 4 | | | | | \$ | \$ | | \$ | \$ | \$ | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | | | | | | | |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | 13 |
| 14 | | | | | | | | | | | 14 |
| 15 | | | | | | | | | | | 15 |
| 16 | | | | | | | | | | | 16 |
| 17 | | | | | | | | | | | 17 |
| 18 | | | | | | | | | | | 18 |
| 19 | | | | | | | | | | | 19 |
| 20 | | | | | | | | | | | 20 |
| 21 | | | | | | | | | | | 21 |
| 22 | | | | | | | | | | | 22 |
| 23 | | | | | | | | | | | 23 |
| 24 | | | | | | | | | | | 24 |
| 25 | | | | | | | | | | | 25 |
| 26 | | | | | | | | | | | 26 |
| 27 | | | | | | | | | | | 27 |
| 28 | | | | | | | | | | | 28 |
| 29 | | | | | | | | | | | 29 |
| 30 | | | | | | | | | | | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | \$ #VALUE! | \$ | | \$ | \$ | \$ | 36 |

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

IF AN ERROR OCCURS IN LINE 35, COLUMN 4, PLEASE
REMOVE THE TEXT FROM COLUMN 2 OR 3.

Print Page 12

STATE OF ILLINOIS

Page 12D

Facility Name & ID Numbe KANKAKEE TERRACE

0022897

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

| | 1 Beds* | FOR OHF USE ONLY | 2 Year Acquired | 3 Year Constructed | 4 Cost | 5 Current Book Depreciation | 6 Life in Years | 7 Straight Line Depreciation | 8 Adjustments | 9 Accumulated Depreciation | |
|----|--|------------------|-----------------------|--------------------------|------------|-----------------------------------|-----------------------|------------------------------------|------------------|----------------------------------|----|
| 4 | | | | | \$ | \$ | | \$ | \$ | \$ | 4 |
| 5 | | | | | | | | | | | 5 |
| 6 | | | | | | | | | | | 6 |
| 7 | | | | | | | | | | | 7 |
| 8 | | | | | | | | | | | 8 |
| | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | | | | | | | |
| 9 | | | | | | | | | | | 9 |
| 10 | | | | | | | | | | | 10 |
| 11 | | | | | | | | | | | 11 |
| 12 | | | | | | | | | | | 12 |
| 13 | | | | | | | | | | | 13 |
| 14 | | | | | | | | | | | 14 |
| 15 | | | | | | | | | | | 15 |
| 16 | | | | | | | | | | | 16 |
| 17 | | | | | | | | | | | 17 |
| 18 | | | | | | | | | | | 18 |
| 19 | | | | | | | | | | | 19 |
| 20 | | | | | | | | | | | 20 |
| 21 | | | | | | | | | | | 21 |
| 22 | | | | | | | | | | | 22 |
| 23 | | | | | | | | | | | 23 |
| 24 | | | | | | | | | | | 24 |
| 25 | | | | | | | | | | | 25 |
| 26 | | | | | | | | | | | 26 |
| 27 | | | | | | | | | | | 27 |
| 28 | | | | | | | | | | | 28 |
| 29 | | | | | | | | | | | 29 |
| 30 | | | | | | | | | | | 30 |
| 31 | | | | | | | | | | | 31 |
| 32 | | | | | | | | | | | 32 |
| 33 | | | | | | | | | | | 33 |
| 34 | | | | | | | | | | | 34 |
| 35 | | | | | | | | | | | 35 |
| 36 | PLEASE REMOVE TEXT FROM COLUMNS 2 OR 3 | | | | \$ #VALUE! | \$ | | \$ | \$ | \$ | 36 |

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Previe

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897**Report Period Beginning: **01/01/2000** Ending: **12/31/2000****XI. OWNERSHIP COSTS (continued)****C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

| | Category of Equipment | 1 Cost | Current Book Depreciation 2 | Straight Line Depreciation 3 | 4 Adjustments | Componen Life 5 | Accumulated Depreciation 6 | |
|----|--------------------------|------------|--------------------------------|---------------------------------|------------------|--------------------|-------------------------------|----|
| 37 | Purchased in Prior Years | \$ 312,869 | \$ 27,119 | \$ 31,287 | \$ 4,168 | 10 YRS | \$ 169,607 | 37 |
| 38 | Current Year Purchases | 17,917 | 2,561 | 896 | (1,665) | 10 YRS | 896 | 38 |
| 39 | Fully Depreciated Assets | 205,810 | | | | | 205,810 | 39 |
| 40 | | | | | | | | 40 |
| 41 | TOTALS | \$ 536,596 | \$ 29,680 | \$ 32,183 | \$ 2,503 | | \$ 376,313 | 41 |

D. Vehicle Depreciation (See instructions.)*

| | 1 Use | Model, Make and Year 2 | Year Acquired 3 | 4 Cost | Current Book Depreciation 5 | Straight Line Depreciation 6 | 7 Adjustments | Life in Years 8 | Accumulated Depreciation 9 | |
|----|----------|---------------------------|--------------------|-----------|--------------------------------|---------------------------------|------------------|--------------------|-------------------------------|----|
| 42 | | | | \$ | \$ | \$ | \$ | | \$ | 42 |
| 43 | | | | | | | | | | 43 |
| 44 | | | | | | | | | | 44 |
| 45 | | | | | | | | | | 45 |
| 46 | TOTALS | | | \$ | \$ | \$ | \$ | | \$ | 46 |

E. Summary of Care-Related Assets

| | 1 | 2 | |
|----|--|--------------|----|
| | Reference | Amount | |
| 47 | Total Historical Cost (line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4) | \$ #VALUE! | 47 |
| 48 | Current Book Depreciation (line 36,col.5 + line 41,col.2 + line 46,col.5) | \$ 115,958 | 48 |
| 49 | Straight Line Depreciation (line 36,col.7 + line 41,col.3 + line 46,col.6) | \$ 119,410 | 49 |
| 50 | Adjustments (line 36,col.8 + line 41,col.4 + line 46,col.7) | \$ 3,452 | 50 |
| 51 | Accumulated Depreciation (line 36,col.9 + line 41,col.6 + line 46,col.9) | \$ 1,770,224 | 51 |

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

| | 1 Description & Year Acquired | 2 Cost | Current Book Depreciation 3 | Accumulated Depreciation 4 | |
|----|----------------------------------|-----------|--------------------------------|-------------------------------|----|
| 52 | | \$ | \$ | \$ | 52 |
| 53 | | | | | 53 |
| 54 | | | | | 54 |
| 55 | | | | | 55 |
| 56 | | | | | 56 |
| 57 | TOTALS | \$ | \$ | \$ | 57 |

G. Construction-in-Progress

| | Description | Cost | |
|----|-------------|------|----|
| 58 | | \$ | 58 |
| 59 | | | 59 |
| 60 | | | 60 |
| 61 | | \$ | 61 |

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Print Preview

XII. RENTAL COSTS**A. Building and Fixed Equipment (See instructions.)**1. Name of Party Holding Lease **N/A**

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

| | | 1 Year Constructed | 2 Number of Beds | 3 Date of Lease | 4 Rental Amount | 5 Total Years of Lease | 6 Total Years Renewal Option* | |
|---|--------------------|--------------------------|------------------------|-----------------------|-----------------------|------------------------------|-------------------------------------|---|
| 3 | Original Building: | | | | \$ | | | 3 |
| 4 | Additions | | | | | | | 4 |
| 5 | | | | | | | | 5 |
| 6 | | | | | | | | 6 |
| 7 | TOTAL | | | | \$ | | | 7 |

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.9. Option to Buy: ☐ YES ☐ NO Terms: _____ ***B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)**

15. Is Movable equipment rental included in building rental?

☐ YES ☐ NO16. Rental Amount for movable equipm: \$ **10,690** Description: **SEE SCHEDULE ATTACHED**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

| | 1 Use | 2 Model Year and Make | 3 Monthly Lease Payment | 4 Rental Expense for this Period | |
|----|-------------------|-----------------------------|-------------------------------|--|----|
| 17 | ADMINISTRATOR | 98 JEEP CHEROKEE | \$ 450.00 | \$ 5,400 | 17 |
| 18 | MAINT, ACT, NURS | 98 FORD VAN | 650.00 | 7,800 | 18 |
| 19 | SMART LEASE | GMAC | 401.00 | 3,206 | 19 |
| 20 | PAYROLL DEDUCTION | | 475.00 | (5,700) | 20 |
| 21 | TOTAL | | \$ ##### | \$ 10,706 | 21 |

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. _____/2001 \$ _____

13. _____/2002 \$ _____

14. _____/2003 \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

nt

Facility Name & ID Number KANKAKEE TERRACE# 0022897

Report Period Beginning: 01/01/2000 Ending: 12/31/2000

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)**A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)**1. HAVE YOU TRAINED AIDES
DURING THIS REPORT
PERIOD?☐ YES☒ NOIf "yes", please complete the remainder
of this schedule. If "no", provide an
explanation as to why this training was
not necessary.**THE FACILITY HIRES ONLY TRAINED AIDES.**2. CLASSROOM PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐COMMUNITY COLLEGE ☐

HOURS PER AIDE _____

3. CLINICAL PORTION:IN-HOUSE PROGRAM ☐IN OTHER FACILITY ☐

HOURS PER AIDE _____

B. EXPENSES**ALLOCATION OF COSTS (d)**

| | | 1 | 2 | 3 | 4 |
|----|---------------------------------|-----------|-----------|----------|-------|
| | | Facility | | | |
| | | Drop-outs | Completed | Contract | Total |
| 1 | Community College Tuition | \$ | \$ | \$ | \$ |
| 2 | Books and Supplies | | | | |
| 3 | Classroom Wages (a) | | | | |
| 4 | Clinical Wages (b) | | | | |
| 5 | In-House Trainer Wages (c) | | | | |
| 6 | Transportation | | | | |
| 7 | Contractual Payments | | | | |
| 8 | Nurse Aide Competency Tests | | | | |
| 9 | TOTALS | \$ | \$ | \$ | \$ |
| 10 | SUM OF line 9, col. 1 and 2 (e) | \$ | | | |

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.

(c) For in-house training programs only. Do not include fringe benefits.

(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$ **D. NUMBER OF AIDES TRAINED**

| COMPLETED | |
|------------------------------|--|
| 1. From this facility | |
| 2. From other facilities (f) | |
| DROP-OUTS | |
| 1. From this facility | |
| 2. From other facilities (f) | |
| TOTAL TRAINED | |

(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Print Preview

our
ies.

Facility Name & ID Number **KANKAKEE TERRACE**# **0022897** Report Period Beginning: **01/01/2000** Ending: **12/31/2000****XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | |
|----|--|--|---------------------|------|---|------|--------------------------------------|-------------------------------|--------------------------------|----|
| | Service | Schedule V Line & Column Reference | Staff | | Outside Practitioner (other than consultant) | | Supplies (Actual or Allocated) | Total Units (Column 2 + 4) | Total Cost (Col. 3 + 5 + 6) | |
| | | | Units of Service | Cost | Units | Cost | | | | |
| | | | | | | | | | | |
| 1 | Licensed Occupational Therapist | | hrs | \$ | | \$ | \$ | | \$ | 1 |
| 2 | Licensed Speech and Language Development Therapist | | hrs | | | | | | | 2 |
| 3 | Licensed Recreational Therapist | | hrs | | | | | | | 3 |
| 4 | Licensed Physical Therapist | | hrs | | | | | | | 4 |
| 5 | Physician Care | | visits | | | | | | | 5 |
| 6 | Dental Care | | visits | | | | | | | 6 |
| 7 | Work Related Program | | hrs | | | | | | | 7 |
| 8 | Habilitation | | hrs | | | | | | | 8 |
| 9 | Pharmacy | | # of prescripts | | | | | | | 9 |
| | Psychological Services (Evaluation and Diagnosis/ Behavior Modification) | | hrs | | | | | | | 10 |
| 11 | Academic Education | | hrs | | | | | | | 11 |
| 12 | Exceptional Care Program | | | | | | | | | 12 |
| 13 | Other (specify): | | | | | | | | | 13 |
| 14 | TOTAL | | | \$ | | \$ | \$ | | \$ | 14 |

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

[Print Preview](#)

STATE OF ILLINOIS

Page 17

Facility Name & ID Number KANKAKEE TERRACE

0022897

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/2000 (last day of reporting year)

This report must be completed even if financial statements are attached.

| | | 1 Operating | 2 After Consolidation* | |
|----|--|----------------|------------------------------|----|
| | A. Current Assets | | | |
| 1 | Cash on Hand and in Banks | \$ 177,549 | \$ | 1 |
| 2 | Cash-Patient Deposits | | | 2 |
| 3 | Accounts & Short-Term Notes Receivable-Patients (less allowance 60,000) | 863,561 | | 3 |
| 4 | Supply Inventory (priced at) | | | 4 |
| 5 | Short-Term Investments | | | 5 |
| 6 | Prepaid Insurance | 87,195 | | 6 |
| 7 | Other Prepaid Expenses | 37 | | 7 |
| 8 | Accounts Receivable (owners or related parties) | 146,678 | | 8 |
| 9 | Other(specify): | | | 9 |
| 10 | TOTAL Current Assets (sum of lines 1 thru 9) | \$ 1,275,020 | \$ | 10 |
| | B. Long-Term Assets | | | |
| 11 | Long-Term Notes Receivable | 1,183,122 | | 11 |
| 12 | Long-Term Investments | | | 12 |
| 13 | Land | 100,000 | | 13 |
| 14 | Buildings, at Historical Cost | 1,233,000 | | 14 |
| 15 | Leasehold Improvements, at Historical Cost | 1,285,381 | | 15 |
| 16 | Equipment, at Historical Cost | 536,596 | | 16 |
| 17 | Accumulated Depreciation (book methods) | (1,833,899) | | 17 |
| 18 | Deferred Charges | 30,850 | | 18 |
| 19 | Organization & Pre-Operating Costs | | | 19 |
| 20 | Accumulated Amortization - Organization & Pre-Operating Costs | | | 20 |
| 21 | Restricted Funds | | | 21 |
| 22 | Other Long-Term Assets (specify): | | | 22 |
| 23 | Other(specify): | | | 23 |
| 24 | TOTAL Long-Term Assets (sum of lines 11 thru 23) | \$ 2,535,050 | \$ | 24 |
| 25 | TOTAL ASSETS (sum of lines 10 and 24) | \$ 3,810,070 | \$ | 25 |

| | | 1 Operating | 2 After Consolidation* | |
|----|--|----------------|------------------------------|----|
| | C. Current Liabilities | | | |
| 26 | Accounts Payable | \$ 623,594 | \$ | 26 |
| 27 | Officer's Accounts Payable | | | 27 |
| 28 | Accounts Payable-Patient Deposits | | | 28 |
| 29 | Short-Term Notes Payable | | | 29 |
| 30 | Accrued Salaries Payable | 58,300 | | 30 |
| 31 | Accrued Taxes Payable (excluding real estate taxes) | 24,959 | | 31 |
| 32 | Accrued Real Estate Taxes(Sch.IX-B) | 46,400 | | 32 |
| 33 | Accrued Interest Payable | | | 33 |
| 34 | Deferred Compensation | | | 34 |
| 35 | Federal and State Income Taxes | | | 35 |
| | Other Current Liabilities(specify): | | | |
| 36 | | | | 36 |
| 37 | | | | 37 |
| 38 | TOTAL Current Liabilities (sum of lines 26 thru 37) | \$ 753,253 | \$ | 38 |
| | D. Long-Term Liabilities | | | |
| 39 | Long-Term Notes Payable | 2,340,063 | | 39 |
| 40 | Mortgage Payable | | | 40 |
| 41 | Bonds Payable | | | 41 |
| 42 | Deferred Compensation | | | 42 |
| | Other Long-Term Liabilities(specify): | | | |
| 43 | LOAN - CORUS BANK | 760,000 | | 43 |
| 44 | | | | 44 |
| 45 | TOTAL Long-Term Liabilities (sum of lines 39 thru 44) | \$ 3,100,063 | \$ | 45 |
| 46 | TOTAL LIABILITIES (sum of lines 38 and 45) | \$ 3,853,316 | \$ | 46 |
| 47 | TOTAL EQUITY(page 18, line 24) | \$ (43,246) | \$ | 47 |
| 48 | TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47) | \$ 3,810,070 | \$ | 48 |

*(See instructions.)

Print Preview

XVI. STATEMENT OF CHANGES IN EQUITY

| | | 1 Total | |
|-----------|---|--------------------------|-------------|
| 1 | Balance at Beginning of Year, as Previously Reported | \$ (460,062) | 1 |
| 2 | Restatements (describe): | | 2 |
| 3 | | | 3 |
| 4 | | | 4 |
| 5 | | | 5 |
| 6 | Balance at Beginning of Year, as Restated (sum of lines 1-5) | \$ (460,062) | 6 |
| | A. Additions (deductions): | | |
| 7 | NET Income (Loss) (from page 19, line 43) | 953,353 | 7 |
| 8 | Aquisitions of Pooled Companies | | 8 |
| 9 | Proceeds from Sale of Stock | | 9 |
| 10 | Stock Options Exercised | | 10 |
| 11 | Contributions and Grants | | 11 |
| 12 | Expenditures for Specific Purposes | | 12 |
| 13 | Dividends Paid or Other Distributions to Owners | (536,537) | 13 |
| 14 | Donated Property, Plant, and Equipment | | 14 |
| 15 | Other (describe) | | 15 |
| 16 | Other (describe) | | 16 |
| 17 | TOTAL Additions (deductions) (sum of lines 7-16) | \$ 416,816 | 17 |
| | B. Transfers (Itemize): | | |
| 18 | | | 18 |
| 19 | | | 19 |
| 20 | | | 20 |
| 21 | | | 21 |
| 22 | | | 22 |
| 23 | TOTAL Transfers (sum of lines 18-22) | \$ | 23 |
| 24 | BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23) | \$ (43,246) | 24 * |

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

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Facility Name & ID Number KANKAKEE TERRACE

0022897

Report Period Beginning: 01/01/2000

Ending:

12/31/2000

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

| 1 | | | |
|--|---|--------------|-----|
| Revenue | | Amount | |
| A. Inpatient Care | | | |
| 1 | Gross Revenue -- All Levels of Care | \$ 4,364,039 | 1 |
| 2 | Discounts and Allowances for all Levels | () | 2 |
| 3 | SUBTOTAL Inpatient Care (line 1 minus line 2) | \$ 4,364,039 | 3 |
| B. Ancillary Revenue | | | |
| 4 | Day Care | | 4 |
| 5 | Other Care for Outpatients | | 5 |
| 6 | Therapy | | 6 |
| 7 | Oxygen | | 7 |
| 8 | SUBTOTAL Ancillary Revenue (lines 4 thru 7) | \$ | 8 |
| C. Other Operating Revenue | | | |
| 9 | Payments for Education | | 9 |
| 10 | Other Government Grants | | 10 |
| 11 | Nurses Aide Training Reimbursements | | 11 |
| 12 | Gift and Coffee Shop | | 12 |
| 13 | Barber and Beauty Care | | 13 |
| 14 | Non-Patient Meals | | 14 |
| 15 | Telephone, Television and Radio | | 15 |
| 16 | Rental of Facility Space | | 16 |
| 17 | Sale of Drugs | | 17 |
| 18 | Sale of Supplies to Non-Patients | | 18 |
| 19 | Laboratory | | 19 |
| 20 | Radiology and X-Ray | | 20 |
| 21 | Other Medical Services | | 21 |
| 22 | Laundry | | 22 |
| 23 | SUBTOTAL Other Operating Revenue (lines 9 thru 22) | \$ | 23 |
| D. Non-Operating Revenue | | | |
| 24 | Contributions | | 24 |
| 25 | Interest and Other Investment Income*** | 106,552 | 25 |
| 26 | SUBTOTAL Non-Operating Revenue (lines 24 and 25) | \$ 106,552 | 26 |
| E. Other Revenue (specify):**** | | | |
| 27 | Settlement Income (Insurance, Legal, Etc.) | | 27 |
| 28 | DISCOUNTS | | 28 |
| 28a | | | 28a |
| 29 | SUBTOTAL Other Revenue (lines 27, 28 and 28a) | \$ | 29 |
| 30 | TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29) | \$ 4,470,591 | 30 |

| 2 | | | |
|-------------------------------------|--|--------------|----|
| Expenses | | Amount | |
| A. Operating Expenses | | | |
| 31 | General Services | \$ 788,275 | 31 |
| 32 | Health Care | 1,195,436 | 32 |
| 33 | General Administration | 1,007,690 | 33 |
| B. Capital Expense | | | |
| 34 | Ownership | 448,173 | 34 |
| C. Ancillary Expense | | | |
| 35 | Special Cost Centers | | 35 |
| 36 | Provider Participation Fee | 77,664 | 36 |
| D. Other Expenses (specify): | | | |
| 37 | | | 37 |
| 38 | | | 38 |
| 39 | | | 39 |
| 40 | TOTAL EXPENSES (sum of lines 31 thru 39)* | \$ 3,517,238 | 40 |
| 41 | Income before Income Taxes (line 30 minus line 40)** | 953,353 | 41 |
| 42 | Income Taxes | | 42 |
| 43 | NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42) | \$ 953,353 | 43 |

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

| | | 1 | 2** | 3 | 4 | |
|----|---------------------------------|---------------------------------|----------------------------------|--|---------------------------|----|
| | | # of Hrs. Actually Worked | # of Hrs. Paid and Accrued | Reporting Period Total Salaries, Wages | Average Hourly Wage | |
| 1 | Director of Nursing | 2,080 | 2,080 | \$ 50,200 | \$ 24.13 | 1 |
| 2 | Assistant Director of Nursing | | | | | 2 |
| 3 | Registered Nurses | 6,928 | 7,452 | 132,962 | 17.84 | 3 |
| 4 | Licensed Practical Nurses | 8,790 | 9,461 | 145,050 | 15.33 | 4 |
| 5 | Nurse Aides & Orderlies | 48,880 | 55,615 | 546,507 | 9.83 | 5 |
| 6 | Nurse Aide Trainees | | | | | 6 |
| 7 | Licensed Therapist | | | | | 7 |
| 8 | Rehab/Therapy Aides | 4,290 | 5,600 | 57,634 | 10.29 | 8 |
| 9 | Activity Director | | | | | 9 |
| 10 | Activity Assistants | 6,989 | 7,635 | 56,835 | 7.44 | 10 |
| 11 | Social Service Workers | | | | | 11 |
| 12 | Dietician | | | | | 12 |
| 13 | Food Service Supervisor | | | | | 13 |
| 14 | Head Cook | | | | | 14 |
| 15 | Cook Helpers/Assistants | 16,796 | 18,960 | 169,032 | 8.92 | 15 |
| 16 | Dishwashers | | | | | 16 |
| 17 | Maintenance Workers | 2,276 | 2,292 | 27,030 | 11.79 | 17 |
| 18 | Housekeepers | 18,191 | 20,640 | 155,318 | 7.53 | 18 |
| 19 | Laundry | 5,136 | 6,311 | 67,543 | 10.70 | 19 |
| 20 | Administrator | 2,080 | 2,179 | 61,141 | 28.06 | 20 |
| 21 | Assistant Administrator | | | | | 21 |
| 22 | Other Administrative | | | | | 22 |
| 23 | Office Manager | | | | | 23 |
| 24 | Clerical | 7,303 | 7,768 | 56,507 | 7.27 | 24 |
| 25 | Vocational Instruction | | | | | 25 |
| 26 | Academic Instruction | | | | | 26 |
| 27 | Medical Director | | | | | 27 |
| 28 | Qualified MR Prof. (QMRP) | 10,765 | 11,170 | 119,631 | 10.71 | 28 |
| 29 | Resident Services Coordinator | | | | | 29 |
| 30 | Habilitation Aides (DD Homes) | | | | | 30 |
| 31 | Medical Records | 1,030 | 1,243 | 12,516 | 10.07 | 31 |
| 32 | Other Health Care(specify) | | | | | 32 |
| 33 | Other(specify) <u>QUALITY A</u> | 2,080 | 2,167 | 20,155 | 9.30 | 33 |
| 34 | TOTAL (lines 1 - 33) | 143,614 | 160,573 | \$ 1,678,061 * | \$ 10.45 | 34 |

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

| | 1 | 2 | 3 | |
|----|---------------------------------|--|------------------------------------|----|
| | Number of Hrs. Paid & Accrued | Total Consultant Cost for Reporting Period | Schedule V Line & Column Reference | |
| 35 | Dietary Consultant | M \$ 5,960 | 1-3 | 35 |
| 36 | Medical Director | O 2,492 | 9-3 | 36 |
| 37 | Medical Records Consultant | N 0 | 10-3 | 37 |
| 38 | Nurse Consultant | T 0 | 10-3 | 38 |
| 39 | Pharmacist Consultant | H 1,680 | 10-3 | 39 |
| 40 | Physical Therapy Consultant | L 1,288 | 10a-3 | 40 |
| 41 | Occupational Therapy Consultant | Y 4,250 | 10a-3 | 41 |
| 42 | Respiratory Therapy Consultant | 0 | 10a-3 | 42 |
| 43 | Speech Therapy Consultant | F 0 | 10a-3 | 43 |
| 44 | Activity Consultant | E 4,225 | 11-3 | 44 |
| 45 | Social Service Consultant | E 1,950 | 12-3 | 45 |
| 46 | Other(specify) | S | | 46 |
| 47 | <u>PSYCHO-SOCIAL CONSULTANT</u> | 0 | 10-3 | 47 |
| 48 | | | | 48 |
| 49 | TOTAL (lines 35 - 48) | \$ 21,845 | | 49 |

C. CONTRACT NURSES

| | 1 | 2 | 3 | |
|----|-------------------------------|----------------------|------------------------------------|----|
| | Number of Hrs. Paid & Accrued | Total Contract Wages | Schedule V Line & Column Reference | |
| 50 | Registered Nurses | \$ | 10-3 | 50 |
| 51 | Licensed Practical Nurses | | 10-3 | 51 |
| 52 | Nurse Aides | | 10-3 | 52 |
| 53 | TOTAL (lines 50 - 52) | \$ | | 53 |

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